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Shrinking the state: The fate of the NHS and social care

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The National Health Service (NHS) and local government-funded social care services are being challenged financially like never before. Real expenditure on the NHS has increased by less than 1% a year since 2010, and from 2018 there is no planned increase at all.[1,2] In the face of ever-increasing demand, care quality is unavoidably being eroded. In an attempt to hide extensive failures to meet them, waiting time targets for elective surgery and emergency care are being 'reset' with more flexibility. Patient discharges are increasingly being delayed by declining social care provision. How can we explain the government's persistent reluctance to address funding shortages, and are policy responses likely to sustain patient care?

Government is defending their ideologically driven response to 'austerity' by ensuring a stalemate with regard to NHS and social care funding. The purpose of this negative approach is to achieve a smaller state. Public expenditure as a percentage of GDP has been reduced from 45% in 2010 to 40% in 2016. Some in Government wish to push this percentage even lower if this means the privatisation of NHS funding.

Public servants in NHS England are trying to break this deadlock and reduce pressures on patients and their carers. They are confronted by significant swings to the political right across Europe and elsewhere. They see the expenditure reductions in defence, the police and prisons as undermining the quality of public life just as the underfunding of the NHS is damaging the health of patients.

The political 'game' of shrinking the size of the State is a fascinating struggle to determine the fate of valuable and vulnerable elements of the embattled welfare state as well as the overall quality of civil society.

The government's performance

The first thing to emphasise is that 'austerity' is a political choice. The Coalition and the current government have responded to the collapses in the banking sector in 2008–2009 by reducing government expenditure. A large government deficit, wisely created to mitigate the banking crisis, is being used as a threat, particularly to support major reductions in the quantity and quality of public services.

For the NHS and social care, this has meant severe reductions in expenditure. In 2010, local authorities funded social care for 700,000 frail elderly people. Now only 400,000 are cared in this way. Similar cutbacks have taken place in services for children and other vulnerable groups. Local government budget cuts have been large, nearly 25%, and have been levied unevenly, varying from 46.3% in some areas and only 6.2% in other places.[3] This 'gerrymandering' of financial allocations has discriminated severely against some large northern cities, thereby hitting deprived areas hardest.

The NHS has also been subjected to cynical sophistry, with financial constraint in the face of increasing demand. The growth of multi-morbidity has been significant across all age groups, and especially the elderly. Technological change has produced new cancer and HIV drugs as well as sophisticated scanning and other diagnostic capacity. Furthermore, existing equipment and plant has depreciated leaving an estimated shortfall in maintenance of nearly £1 billion.

The government's response to the growth in demand for NHS funds has been meagre. Annual increases of circa 0.8% and 'socialist' incomes policies have distorted the workforce, for example by creating a secondary market in agency workers which inflated wage costs by circa £3 billion. Deliberate short-termism has created significant medium-term workforce recruitment and retention problems.

The future funding of health and social care remains poor. NHS England's Five Year Forward View[4] set out estimated funding needs up to the year 2020. A guestimated need for additional funding of £30 billion emerged, of which £8 billion was to be tax financed. The remaining £22 billion was to come from increased productivity.

The consequent funding pressures have created further political chicanery. For example, currently the government has fragmented the component parts of the NHS and its funding streams. By cutting budgets for public health and NHS workforce education, the government has 'freed up' resources for the delivery of NHS clinical care. The government claims a 'generous' settlement has been made for the period up to 2020. However, the actual figure is not a claimed £10 billion but £4.6 billion front-loaded for the early years of the 2016–2020 period.[5] Furthermore, this planned outcome involves significant reductions in public health investment and reduced training at a time of increased medical school intake and increased demand for nursing and other clinical staff.

The public servants' reaction

Public apathy to the fate of the NHS and social care is a product of political rhetoric claiming that the NHS and social care have done 'quite well considering austerity' and the government's desire to reduce public expenditure. The popular press tends to focus on individual patient crises and sectional demands for unproven new drugs as a means of denigrating the astonishing performance of public services stressed beyond the comprehension of the ill-informed public.

NHS England has the responsibility of providing the productivity improvements required by the Five Year Forward View.[4] The politics of this are simple. Simon Stevens and his NHS England colleagues are embarking on plans for radical reorganisation of the structures used to deliver health and social care to patients.

Sustainability and transformational plans (STPs) have been devised for all areas of the country which, to varying degrees, posit changes in primary care, hospital care and local authority social care.

The changes involve varying degrees of vertical and horizontal integration. In Suffolk, for example, there are plans for the horizontal integration of all GP practices. In Northumbria, there are plans to vertically integrate primary, hospital and social care services. There are plans for hospital mergers and efficiency 'gains' in numerous parts of the country, e.g. plans for the merger of Nottingham hospital and Sherwood hospital have been proposed and lately abandoned.

There appears to be a general belief that integration will enable savings to bridge the funding gap threatening the viability of NHS health and social care. These reforms mirror the healthcare debate in the USA where unwarranted clinical practice variations in the private and public sectors have led policy makers to changes including different payment structures and merged organisations. Since the creation of 'Obamacare' six years ago, the investment in Accountable Care Organisations (ACOs), with their emphasis on 'value' (outcomes) and new incentive systems, has been considerable.

The question for these American innovations and NHS STPs is the same: where is the evidence of cost effectiveness? The managers of NHS England have emulated experimental American policy changes and encouraged NHS and local government decision makers to innovate in similar ways, without plans to pilot and evaluate, and with hope rather than evidence to back their proposed reforms.

The variety of STP programmes is both remarkable and contentious. For instance, one STP is proposing massive skill dilution of the nursing workforce, replacing registered nurses and physicians with nursing assistants and physician assistants. At the same time, nursing researchers continue to reiterate that increased staffing by qualified nurses reduces patient mortality and morbidity.[6]

Both in the US and in NHS STPs, there is strong advocacy of hospital mergers. Evidence of the cost effectiveness of this policy is sparse with US studies showing less concentrated markets have better quality care and lower prices.[7] UK evidence shows no beneficial effects of mergers and a concern that consequent lack of competition will have adverse effects on patient outcomes. A study concluded that 'mergers are not an appropriate way of dealing with poorly performing hospitals'.[8]

American ACOs now involve attempts to bundle primary, hospital and community care. They offer a focus on outcomes, targeting high users of care and capitated budgets with incentives to share saved costs. Such attributes are welcome but integrating NHS primary and secondary care with grossly under-funded local government is complex, especially as the latter's services are means tested and the former is free.

The changes proposed in STPs require significant investments in capital which are absent. Furthermore, the timescale is highly unlikely to generate savings of the order of £22 billion in the time scale required.

The end game

All governments are amalgams of left and right wing preferences. The current UK government is no exception. In the early 1980s, the preference of the then Prime Minister, Margaret Thatcher, was to alter NHS funding and develop private insurance.

That option, lost in the 1980s, continues to be advocated by the apostles of 'free markets'.

Public finances are in a parlous state and the preference for austerity as a means of reducing public sector indebtedness and creating a smaller state remains dominant in the current government. The anticipated effects of Brexit seem likely to exacerbate Britain's fiscal problems. Salvation from efficiency savings from STPs and the Five Year Forward Plan seems illusory. Particularly, in the short term and with a paucity of capital funds to engineer rapid infrastructure change, the achievement of productivity gains will be slow at best to manifest themselves.

The politics of the NHS and social care involve a tug of war between a government adamant that these services have had a 'good' financial settlement and deserve no more, and NHS England bent on pursuing increased productivity by £22 billion (20% in the five years to 2020). As the quality and quantity of patient care erodes, the disruption caused by STP-induced radical changes may precipitate a political storm obliging more tax finance or changes in ways of funding the NHS and social care. The outcome for patients rests on political preferences and the tactics of government and those seeking to defend a vulnerable and long standing pillar of the welfare state.

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